GORDON FAMILY PHARMACY
518 S Broad St., Brevard, NC 28712
PHONE: 828-877-6111
FAX: 828-877-6487
EMAIL: gordonfamilypharmacy@gmail.com

ROCKBROOK CAMP FOR GIRLS
PHARMACY FORM 2022

GORDON FAMILY PHARMACY WILL DO ITS BEST TO PROCESS PRESCRIPTIONS THROUGH YOUR INSURANCE. PLEASE UNDERSTAND THAT SOME INSURANCE COMPANIES DO NOT CONTRACT WITH ALL PHARMACIES. YOU ARE FULLY LIABLE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE, PLUS A $2.50 FEE GORDON CHARGES FOR EACH BLISTER PACK.

CAMP SESSION START DATE: ________________ SESSION END DATE: ____________________
***This form is due 30 days prior to the start of your camp session.

ALL FIELDS ARE REQUIRED:

Camper's First and Last Name: ______________________________ Date of Birth: _________________
Street Address: ____
City/State/Zip: ____
Camper Drug Allergies:____

Name of Current Pharmacy ______________________________ Current Pharmacy Phone ____________

Insurance Company Name: ____
Name of Policy Cardholder: ____
Address of Cardholder: ____
Cardholder ID # _______________________ RxGroup # __________________________
RxBin # _____________________________ RxPCN #____________________________

List prescription medications to be transferred: ____
____
Over-the-counter medications needed: ____

PLEASE ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARD TO THIS FORM

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, AND CHARGES FOR OVER THE COUNTER MEDICATION WHICH I AUTHORIZE TO BE CHARGED DIRECTLY TO MY CREDIT CARD BY GORDON FAMILY PHARMACY. IF I AM SUBMITTING INSURANCE INFORMATION, I AGREE TO AUTHORIZE GORDON FAMILY PHARMACY TO CONTACT MY INSURANCE COMPANY FOR INSURANCE VERIFICATION, BILLING, AND COLLECTIONS FOR MY CHILD'S MEDICATIONS. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE SOLELY MAINTAINED FOR THE PURPOSE OF FILLING PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS.

Parent/Guardian printed name: ____

Parent/Guardian signature: _____________________________ Date: ___________________

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PAYMENT AGREEMENT

WE REQUIRE THAT YOU SUBMIT A CREDIT CARD NUMBER TO COVER ALL MEDICATIONS AND THE BLISTER PACKAGING FEE.

OUR PHARMACY DOES NOT ACCEPT AMERICAN EXPRESS

Name on Card: ____

Credit Card Number: ____

Expiration Date: ______________________ CVV# ________________

Credit Card Type: ______________________ Zip Code: ________________

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, AND CHARGES FOR OVER-THE-COUNTER MEDICATION AUTHORIZED TO BE CHARGED. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE MAINTAINED SOLELY FOR THE PURPOSE OF FILLING PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS AND PAYMENTS.

Parent/Guardian printed name: ____

Parent/Guardian phone number: ____

Parent/Guardian signature: ___________________________ Date: ________________

Please return this form (with your insurance information) directly to Gordon Family Pharmacy via Email, FAX, or USMail.

Please feel free to contact Gordon Family Pharmacy with your questions.